

ONLINE SUPPLEMENT

Supplement to: Shah et al. Poor glycemic control is associated with more rapid kidney function decline after the onset of diabetic kidney disease.

CONTENTS:

PERL Study Group.....3

Supplementary Figure S1.....6

Supplementary Figure S2.....7

Supplementary Figure S3.....8

Supplementary Table S1.....9

Supplementary Table S2.....10

Supplementary Table S3.....11

PERL Study Group

Principal Investigators*: Alessandro Doria (Joslin Diabetes Center), Michael Mauer (University of Minnesota)

Steering Committee*: Ronnie Aronson (LMC Diabetes), Maria Luiza Caramori (University of Minnesota), Jill P. Crandall (Albert Einstein College of Medicine), Ian H. de Boer (University of Washington), Alessandro Doria (Joslin Diabetes Center), John H. Eckfeldt (University of Minnesota), Thomas G. Elliott (BCDiabetes), Michael Flessner (NIDDK), Andrzej T. Galecki (University of Michigan), Allison B. Goldfine (Joslin Diabetes Center), Irl B. Hirsch (University of Washington), Amy B. Karger (University of Minnesota), Ildiko Lingvay (University of Texas Southwestern Medical Center), David M. Maahs (Stanford University), Michael Mauer (University of Minnesota), Janet B. McGill (Washington University), Mark E. Molitch (Northwestern University), Helen Nickerson (JDRF), Afshin Parsa (NIDDK), Bruce A. Perkins (University of Toronto), Sarit Polsky (Barbara Davis Center for Diabetes), Rodica Pop-Busui (University of Michigan), Marlon Pragnell (JDRF), Sylvia E. Rosas (Joslin Diabetes Center), Peter Rossing (Steno Diabetes Center), Peter Senior (University of Alberta), Ronald J. Sigal (University of Calgary), Catherine Spino (University of Michigan), Katherine R. Tuttle (Providence Health Care, University of Washington), Guillermo E. Umpierrez (Emory University)

Data Coordinating Center (University of Michigan)*: Donna DiFranco Andrzej T. Galecki†, Massimo Pietropaolo, Catherine Spino†, Yi-Miau Tsai, Chunyi Wu

Central Laboratory (University of Minnesota): John H. Eckfeldt‡, Amy B. Karger†

Study Psychologist (University of Minnesota): William Robiner

NIDDK: Michael Flessner, Afshin Parsa

JDRF: Helen Nickerson, Marlon Pragnell

Clinical Sites

Joslin Diabetes Center (Boston, MA)

Joslin Diabetes Center: Alessandro Doria¶, Allison B. Goldfine‡, Sylvia Rosas†

Massachusetts General Hospital: Enrico Cagliero

University of Massachusetts: Michael Thompson

SUNY Upstate Medical University Syracuse NY: Ruth S. Weinstock

Steno Diabetes Center (Copenhagen, Denmark)

Christina Gjerlev-Poulsen, Maria Lajer, Frederik Persson, Sascha Pilemann-Lyberg, Peter Rossing†, Signe A. Winther

University of Minnesota (Minneapolis, MN)

University of Minnesota: Maria Luiza Caramori†, Michael Mauer¶

Gundersen Health System: Mary Frohauer†, San Thida

Barbara Davis Center for Diabetes (Denver, CO)

Barbara Davis Center for Diabetes: Peter Gottlieb, David Maahs‡, Sarit Polsky†, Viral Shah

Kaiser Permanente Colorado Institute of Health Research (Denver): Emily Schroeder

University of Colorado Hospital: Michael McDermott

University of Michigan (Ann Arbor, MI)

University of Michigan: Lynn Ang, Frank C. 3rd Brosius, Nazanene H. Esfandiari, Kara Mizokami-Stout, Rodica Pop-Busui†

VA Medical Center Ann Arbor: Rachel Perlman

Henry Ford Medical Center: Arti Bhan, Davida Kruger

Northwestern University (Chicago, IL)

Wenyu Huang, Mark E. Molitch†, Amisha Wallia

Albert Einstein College of Medicine (New York, NY)

Albert Einstein College of Medicine: Matthew K. Abramowitz, Valentin Anghel, Erika Brutsaert, Jill P. Crandall†, Nithya Mani, Divya Rajasekaran

Icahn School of Medicine at Mount Sinai: Carol Levy, Selassie Ogyaadu

Weill Cornell Medical Center: Melissa Katz, Naina Sinha Gregory

Winthrop University Hospital: Nobuyuki Bill Miyawaki, Shayan Shirazian

Jacobi Hospital: Ulrich K. Schubart

University of Toronto (Toronto, ON, Canada)

Mt. Sinai Hospital and University of Toronto: David Cherney, Bruce A. Perkins†

Women's College Hospital: Lorraine L. Lipscombe

St. Michael Hospital: Andrew Advani

LMC Diabetes & Endocrinology: Ronnie Aronson, Ronald Goldenberg

Washington University (St. Louis, MO)

Janet B. McGill†, Amy Riek, Maamoun Salam

University of Calgary (Calgary, AL, Canada)

Julie McKeen, Ronald J. Sigal†

Alberta Diabetes Institute, University of Alberta (Edmonton, AL, Canada)

Peter Senior†, Rose Yeung

Emory University/Grady Health System (Atlanta, GA)

Emory University/Grady Health System: J. Sonya Haw, Guillermo E. Umpierrez†

Atlanta Diabetes Associates: Bruce W. Bode

Atlanta VA Medical Center: Darin Olson

University of Washington (Seattle, WA)

University of Washington Medical Center: Maryam Afkarian, Ian H. de Boer†, Irl B. Hirsch‡, Dace L. Trencce

Virginia Mason Medical Center: Grace Lee

University of Texas Southwestern University (Dallas, TX)

Ildiko Lingvay†

Providence Health Care (Spokane, WA)

Radica Alicic, Katherine R. Tuttle†

BCDiabetes (Vancouver, BC, Canada)

Thomas G. Elliott†

* Listed alphabetically by last name.

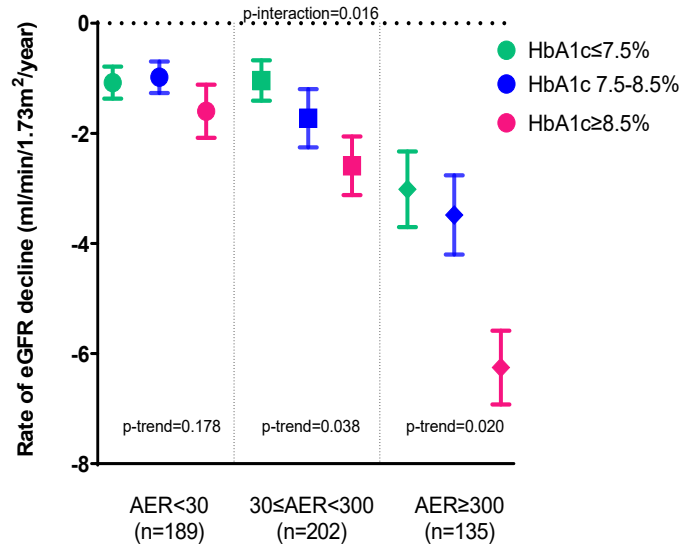
† Director of PERL central unit or clinical site

‡ Former Director of PERL central unit or clinical site

¶ Overall Study PI's

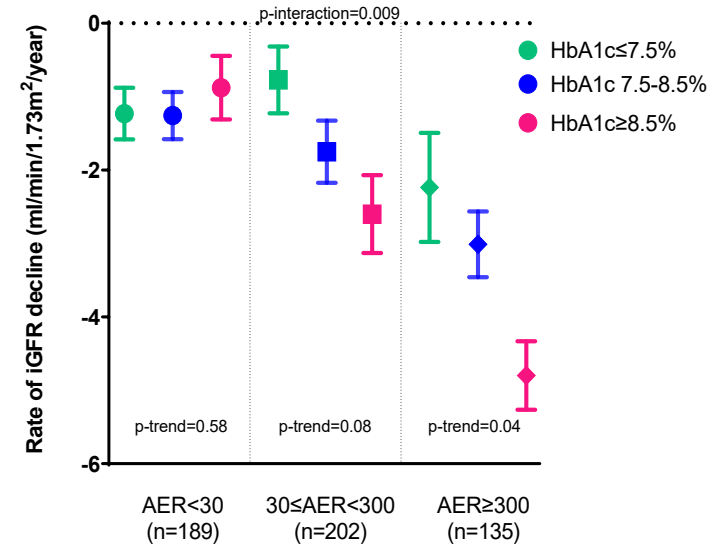
Supplementary Figure S1. Interaction of glycemic control and albuminuria on rate of GFR decline after DKD onset, multivariable adjusted analyses

Suppl. Fig.S1A. Rate of eGFR decline by AER and HbA1c strata in PERL



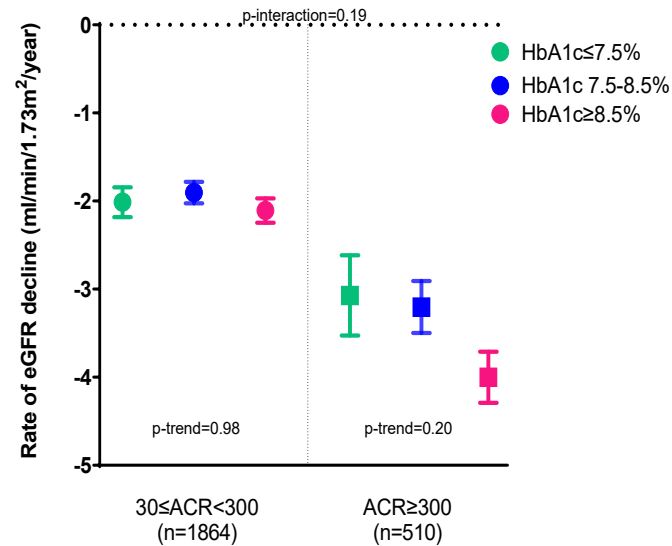
Data points represent beta estimates (±SE) from mixed-effects linear regression models

Suppl. Fig.S1B. Rate of iGFR decline by AER and HbA1c strata in PERL



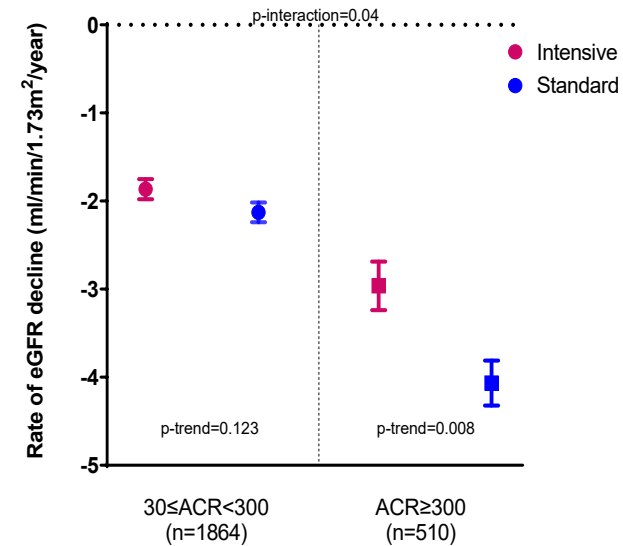
Data points represent beta estimates (±SE) from mixed-effects linear regression models

Suppl. Fig.S1C. Rate of eGFR decline by ACR and HbA1c strata in ACCORD



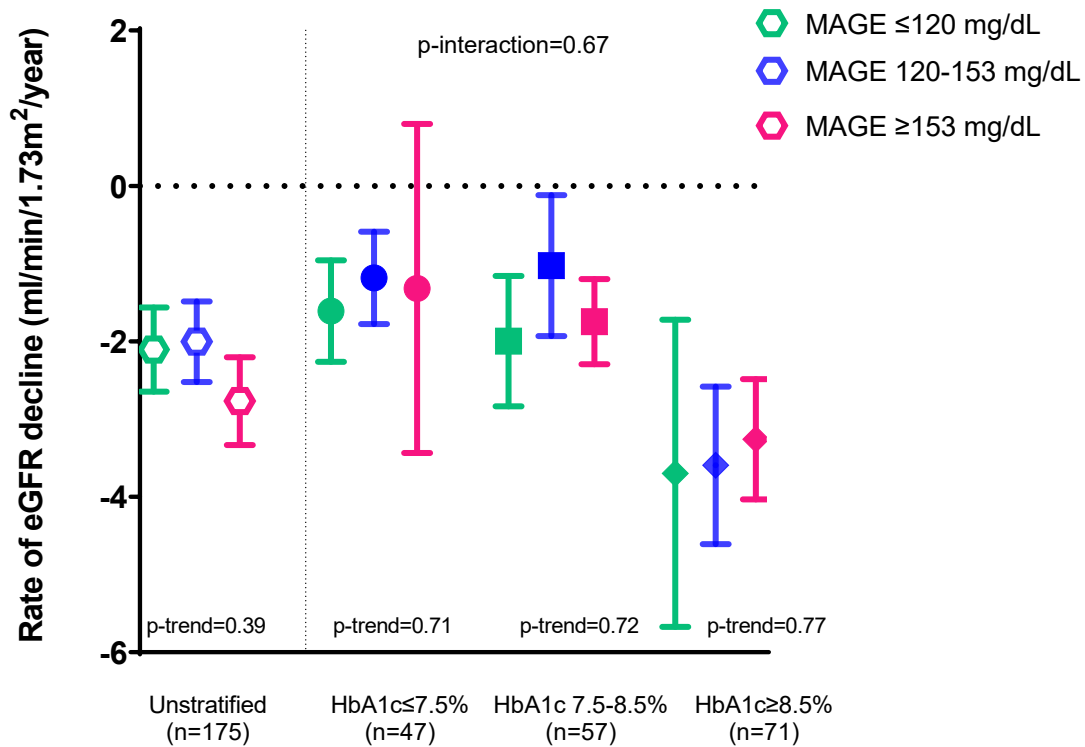
Data points represent beta estimates (±SE) from mixed-effects linear regression models

Suppl. Fig.S1D. Rate of eGFR decline by ACR and Glycemic control groups in ACCORD



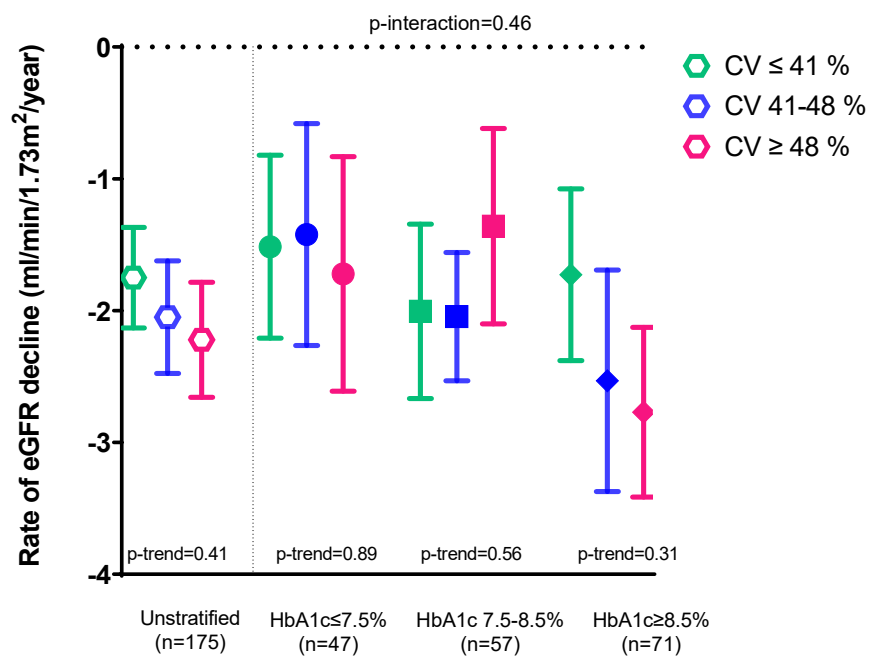
Data points represent beta estimates (±SE) from mixed-effects linear regression models

Suppl. Fig.S2. Rate of eGFR decline by MAGE and HbA1c strata in PERL



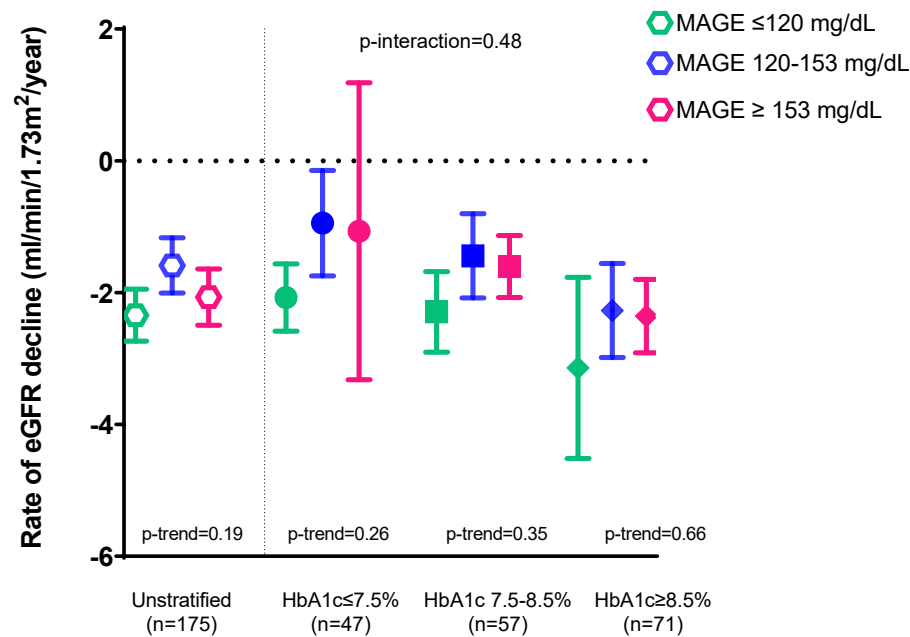
Data points represent beta estimates (±SE) from mixed-effects linear regression models

Suppl.Fig.S3A. Rate of iGFR decline by CV and HbA1c strata in PERL



Data points represent beta estimates (±SE) from mixed-effects linear regression models

Suppl.Fig.S3B. Rate of iGFR decline by MAGE and HbA1c strata in PERL



Data points represent beta estimates (±SE) from mixed-effects linear regression models

Supplementary Table S1. CGM parameter in HbA1c strata in PERL

	CV (%)		MAGE (mg/dL)	
	<i>Mean</i>	<i>Std Dev</i>	<i>Mean</i>	<i>Std Dev</i>
Unstratified [N=175]	45.60	8.68	144.67	43.20
HbA1c≤7.5 % [n=47]	43.55	7.32	125.98	33.95
HbA1c=7.5-8.5 % [n=57]	43.53	7.94	134.82	38.71
HbA1c≥8.5 % [n=71]	48.62	9.29	164.96	44.19

CV=Glucose Coefficient of variation; MAGE=Mean amplitude of glycemic excursions.

Supplementary Table 2. Relationships between baseline characteristics and CV and MAGE in PERL

Baseline Characteristic	CV (%)			MAGE (mg/dL)		
	Est	SE	P	Est	SE	P
Female vs. Male	1.013	1.391	0.468	-14.774	6.837	0.032
Age when diabetes was diagnosed	-0.056	0.059	0.347	-0.229	0.294	0.436
Age (years)	-0.120	0.060	0.047	-0.787	0.296	0.009
Diabetes Duration (years)	-0.059	0.054	0.277	-0.444	0.268	0.100
<i>Race</i> [‡]						
Black vs. White	2.688	1.821	0.142	21.860	8.965	0.016
Other vs. White	1.707	3.617	0.638	-3.937	17.797	0.825
<i>Ethnicity</i>						
Hispanic/Latino vs. Non-Hispanic/Non-Latino	0.738	3.364	0.827	2.335	16.756	0.889
HbA1c (%)	1.382	0.524	0.009	13.232	2.460	<.0001
<i>HbA1c at Visit 1 (%) - tertiles</i>						
HbA1c 7.5-8.5 % vs. HbA1c ≤7.5%	-0.027	1.648	0.987	8.846	7.858	0.262
HbA1c ≥8.5 % vs. HbA1c ≤7.5%	5.067	1.573	0.002	38.979	7.500	<.0001
BMI (kg/m ²)	-0.263	0.103	0.012	-0.927	0.519	0.076
Mean Diastolic Blood Pressure (mm Hg)	0.037	0.064	0.566	0.524	0.317	0.100
Mean Systolic Blood Pressure (mm Hg)	-0.044	0.043	0.307	0.033	0.212	0.876
History of hypertension	-1.240	2.350	0.599	18.675	11.614	0.110
History of smoking	-0.329	1.326	0.804	8.026	6.570	0.224
History of CVD	-4.038	1.552	0.010	-10.964	7.826	0.163
Uric Acid (mg/dl)	-0.389	0.465	0.404	0.367	2.318	0.875
AER (ug/min)	0.001	0.001	0.246	0.006	0.006	0.285
<i>AER strata</i>						
20-200 vs. <20	-0.711	1.466	0.628	9.386	7.244	0.197
≥200 vs. <20	3.252	1.740	0.063	23.890	8.598	0.006
eGFR (ml/min/1.73 m ²)	-0.039	0.034	0.257	0.056	0.171	0.742
iGFR (ml/min/1.73 m ²)	-0.050	0.038	0.193	-0.141	0.191	0.460
<i>Treatment group</i>						
Allopurinol vs. Placebo	-0.229	1.317	0.862	1.997	6.552	0.761
RASI use at baseline	-0.617	2.026	0.761	14.132	10.022	0.160
Taking HMG-CoA inhibitors	-1.326	1.412	0.349	0.572	7.077	0.936

CV=Glucose Coefficient of variation; MAGE=Mean amplitude of glycemic excursions.

Effect estimates (Est), standard errors (SE) and p-values (P) obtained from linear regression models with the CGM parameter

(CV or MAGE) as the dependent variable and the clinical characteristic as the independent variable.

eGFR=estimated glomerular filtration rate from creatinine-based CKD-EPI 2009 equation; iGFR=iohexol GFR. AER=Urinary Albumin excretion rate.

ACR=Urinary albumin-creatinine ratio. CVD=Cardiovascular disease. BMI=Body mass index. RASI=Renin-angiotensin system inhibitors.

[‡]Race was self-reported; "Other" captures American Indian/ Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, Unknown or not-reported;

Supplementary Table S3: Effects of CGM parameters on GFR slopes in PERL

Predictors (x time)	eGFR (ml/min/1.73m ² /year)						iGFR (ml/min/1.73m ² /year)					
	CV (%)			MAGE (mg/dL)			CV (%)			MAGE (mg/dL)		
	<i>Est</i>	<i>SE</i>	<i>P</i>	<i>Est</i>	<i>SE</i>	<i>P</i>	<i>Est</i>	<i>SE</i>	<i>P</i>	<i>Est</i>	<i>SE</i>	<i>P</i>
Model 1: CGM parameter + treatment group	-0.07	0.04	0.04	-0.003	0.01	0.67	-0.02	0.03	0.53	0.00	0.01	0.49
Model 2: Model 1 + baseline HbA1c	-0.06	0.04	0.12	0.01	0.01	0.46	-0.01	0.03	0.73	0.01	0.01	0.17
Model 3: Model 1 + v12to17_a1cmean	-0.07	0.04	0.05	0.001	0.01	0.88	-0.02	0.03	0.55	0.01	0.01	0.32
Model 4: Model 2 + v12to17_a1cmean	-0.06	0.04	0.13	-0.0001	0.01	0.99	-0.01	0.03	0.74	0.01	0.01	0.35

CV=Glucose Coefficient of variation; MAGE=Mean amplitude of glycemic excursions. V12to17_a1cmean= Mean HbA1c between visits 12 to 17 of the PERL trial, when CGM was captured.

eGFR=estimated GFR from creatinine-based CKD-EPI 2009 equation. iGFR=iohexol GFR

Effect estimates (Est), standard errors (SE) and p-values (P) obtained from mixed-effects linear regression models. GFR at each time-point, including baseline, was the dependent variable.

Fixed effects included the time from randomization to GFR assessment, the CGM parameter (CV or MAGE), covariate and the time x CGM/covariate interaction terms; study subjects were random effects.